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The RHODE ISLAND MEDICAL JOURNAL

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THE ETIOLOGY AND TREATMENT OF CHRONIC ULCERATIVE COLITIS (NON-SPECIFIC)*

ANTHONY BASSLER, M.D., F.A.C.P., LL.D.

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I AM PLEASED to discuss certain phases of a disease, varied in clinical presentations, fickle in character, one having considerable mortality and apparently on the increase.

It is a disorder affecting principally young people in the formative and creative years of life, and often those with intelligence above the average. It runs a long course with a pronounced tendency to relapse, and despite much patient investigation, and accumulation of knowledge of various aspects of the illness, it still remains obscure in its etiology, uncertain in its course, and fickle in its response to treatment.

As to the etiologies and the suggestions of treatment that have been advanced in later years, the following are the more important and are presented with certain thoughts and deductions of the writer.

Infectious. Much interest has been attached to the diplococcus or diplostreptococcus of Bargen[1] and Bargen and Logan.[2] It is not a highly virulent pathogen but, like many other intestinal organisms, in certain symbiotic combinations, can become parasitic or be important as a secondary invader but it is not the cause of ulcerative colitis. What has been presented concerning this organism is not biologically much different than any of the usual forms of streptococci met with in the bowel of which most forms met with are the more common types of streptococci.

Paulson[3] produced lesions of the colon with B. coli given parentally and Bassler[4] described a highly toxic hemolytic B. coli as important in the disease.

The B. coli are found in the intestines of all mammals. Of the many forms, using Dunham's classification, no one form can be proven to be definitely infective. Yet the high hemolytic character of the B. coli found in ulcerative colitis, as compared to normal or other intestinal states, gives this organism a significance. In the microscopic pathology found in simple chronic toxic gut states the coli hemolyticus is an important etiologic factor when associated with other organisms especially those of the anerobic group. Coliform organisms represent a family of cousins from the innocent B. coli on one end to the highly pathogenic B. typhosus and B. dysentericus on the other. They must be considered as important in preparing the bowel for subsequent tissue breakdown by a secondary infection bringing on degeneration of the mucosal tissues. With other organisms in the mixed infection, their action is lytic, and by constant reinfection of the mucosa from the lymph structures in and surrounding the gut, a vicious circle is brought about. It is this affinity for the lymphatic structures (the solitary glands in the mucosa, the pericolonic glands immediately outside and the mesentric glands) that is the cause of the recurrences which is the way the disease advances.

The B. dysenteria (paradysentery[5,6]) has occasioned much interest as a cause of ulcerative colitis especially since Felsen's work claiming that ten per cent of cases of acute bacillary dysentery result in a condition simulating chronic ulcerative colitis. What has been stated above in connection with B. coli holds true with this organism which is one of the coliform family.

It was reported by Dragstedt, Dock and Kirsner[7] that they found B. necrophorum in seventy per cent of 298 cases of ulcerative colitis. To me it corresponds to the characteristics of a saprophyte, stimulated in the bowel from the ingestion of milk. I doubt it has significance.

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* Presented at the 137th Annual Meeting of the Rhode Island Medical Society, at Providence, R. I., May 13, 1948.

Allergy. To Andresen[8] must be given the credit of drawing attention to mucous membrane hypersensitiveness to food causing acute ulcers of the colon. Drawing an analogy, allergy became important in chronic ulcerative colitis, this being especially true since Gray and Walzer's[9] contribution. Sensitiveness to foods is common thoughout human beings. One can agree that a person with ulcerative colitis and also allergic to certain foods would aggravate an infected and inflammed colon by eating those foods. On the other hand, food allergies alone cannot produce the picture of chronic ulcerative colitis.

There have been a number of other causes advanced in late years. To save time I will only go into two, avitaminosis and psychosomatic factors. There is an old rule of medicine that "when there are so many causes advanced for a disease none of them are right."

Vitamins. That deficiencies of vitamin intake can cause one to acquire ulcerative colitis cannot be proven and seemingly is a far call for a cause. Cossidering the subnutrition existent throughout the world, especially in the last few years, practically half the world should have chronic ulcerative colitis. While as a disease it is slightly on the increase, it must be agreed that this has nothing to do with vitamin deficiency. On the other hand, because of the diarrhea, a secondary type of avitaminosis occurs which suggests the use of vitamins in a general nutritional sense.

Psychosomatic Factors. Every physician who has handled enough patients with ulcerative colitis has observed instances in which the onset of symptoms followed an active emotional upset, or a relapse or exacerabation occurred for the same reason. The colon is close to the brain and it is not difficult to understand why a patient whose colon is diseased would be locally disturbed by emotional disturbance. But after all that has been written on the subject, an emotional disturbance per se is not the direct cause of ulcerative colitis.

Wittkower[10] reported that constant apprehension, prolonged tension, infantile reaction to fear, financial or occupational worry, attachment to a parent or a relative, fear of pregnancy, domestic or love difficulties, forthcoming examinations, immature sexual conflicts were more frequent in his patients than in the general population. This is no doubt true but they do not occur more frequently than in patients with other conditions in a gastroenterological practice. This is more obvious in instances of so-called mucus colitis, which is a psychosomatic affair, but not ulcerative colitis. The writer has seen nineteen instances of chronic ulcerative colitis treated totally by psychiatric methods without lasting benefit, and twenty-two more were handled by a physician and psychiatrist together seemingly with only slightly more benefit so far as the bowel was concerned.

It is difficult to accept that chronic ulcerative colitis has emotional features as an important cause even though testimony is slowly accumulating to suggest it. Wittkower[10] came to the startling conclusion that ulcerative colitis was a disease of the mentally ill or maladjusted. In my own observations, emotional upsets may be present in about thirty per cent of the cases and in about 25 per cent of gastroduodenal ulcer. These figures are not convincing from an etilogic point of view. Who has the method and ability to judge degrees of mental adjustments? Who has the method and ability to judge how, and why the colon is picked as the battle ground, or why the stomach, the heart, or the kidneys? As Ginsberg and Ivy[11] state, "If these emotional factors are etiologically concerned in the three diseases, why do they affect the stomach in some persons, cause mucus colitis in others, and in still others, as some believe, cause ulcerative colitis?" The writer believes that emotional states occupy about the same significance as allergic factors, namely to unstabilize an already diseased and degenerated colon.

Different workers have made much of chronic ulcerative colitis being a disease of pleomorphous etiological factors. Along the lines soon to be described its development is simple to understand. The error has been that the colon is easily unstabilized for many reasons, and that when any of these factors bring on symptoms, too high a degree of etiological significance is given to them. They disturb the colon physiology, are functional in nature, and are not etiologic in the proper sense.

In using the term "normal" pertaining to the colon one recognizes the wide scope of individual variation within the meaning of the term, variations that are not known or recognized, usually permitting the pathologic conditions of the colon to be overlooked or be designated as "normal". The recent history of the physiology of the colon has largely been advanced by the development of radiological technique and its application to the alimentary tract. Even the motor functions are still very incompletely understood. The automaticity of the colon is more quickly disturbed than any other organ of the abdomen, and if, as modern psychiatrists believe, we think with the brain and all parts of the body, then the colon can be assailed in its function from both within and from anywhere in the body. We must then acknowledge that unless we have a reasonable degree of knowledge of the functions of the colon and how agents may disturb the physiology, we cannot understand its diseases.

Micropathology of the Colon

Microscopic examination of what grossly ap-

pears to be a normal colon usually presents quite an array of minute pathologies. This statement is based on the many instances at autopsy where colon disease was not believed to be present. In observations made years ago in the New York City morgue, the colons of fifty consecutive autopsies in instances where death was dramatically brought about, there were but nine instances of perfectly normal colons from a microscopic standpoint. The findings were:

1. Detachment and lysis of cells of tubules
2. Destruction of tubes
3. Attached and adherent mucus
4. Degenerated mucosa
5. Submucosal edema
6. Enlarged solitary follicles
7. Interior cells of follicles broken down
8. Thickened peritoneum
9. Degenerated nerve cells
10. Endothelial cells of blood vessels detached
11. Blood vessels denuded of cells
12. Hemorrhagic areas
13. Sclerosed arterioles
14. Thickened and sclerosed venules
15. Phlebitis of venules
16. Cell detritis in submucosa
17. Giant cells free in submucosa
18. Free somatic cells
19. Infiltration cells
20. Fibrils of scar tissue
21. Congestion (enlarged) blood vessels
22. Large single and multinucleated cells
23. Many lymphocytoid cells

Unless what we have believed of cellular pathology since Vichow's time is to be scrapped, it is difficult to understand why minute pathology of the colon should continue to receive no attention.

Biotoxic Intestinal States

The baby is born with a sterile intestinal canal which presents swarms of bacteria a few days after birth. The only cause of digestive disturbances in infancy is dietetic never bacterial. For various reasons the so-called natural immunities against these organisms may not be acquired or acquired to high enough degree and a low grade biotoxic condition develops. The mucosa continuously subjected to this toxicity over years of time brings about the micropathologies mentioned. The resistance to bacterial invasion and lytic agents then being lowered, bacterial infection assaults the mucosa with the production of congestion, inflammation and ulceration. When the colon is breaking down structurally it is not a question of this or that bacteria being present and a significance placed on some one as the cause of the disease. Any one of several bacteria is capable of producing it. In fifty cases of well established ulcerative colitis the significant bacteriologies met with were:

Hemolytic streptococci specified types	42 cases
Green streptococci	21 cases
Nonhemolytic strpetococci	17 cases
Alcaligenes fecaloides	33 cases
Staphylococcus albus	31 cases
Clostridium oedematis maligni	25 cases
Escherichia coli specified types	24 cases
Gram positive enterococcus	22 cases
Pseudomonas aeruginosa	19 cases
Clostridium welchii	7 cases
Erythrobacillus prodigiosa	18 cases

I believe that cases of ulcerative colitis start their development early in life in the following sequence: failure to build up the intestinal immunities required, a series of departures of normal physiology of the colon, a biotoxic gut state causing micropathologies in the colon mucosa, the effects of different agents unstabilizing the bowel, secondary bacterial infection, and reinfection from the lymph strictures.

Matters Pertaining to Classification

The use of the term cure in connection with chronic ulcerative colitis cannot be used. I agree with Kiefer[12] that the term control as good, fair and poor is all that is permissible. By good is meant where both the local and general constitutional symptoms have been absent for three years, the patient being active and capable to stand strains, physical and emotional, eating any foods, no treatment, etc., without ill effect. By fair is meant that marked improvement had taken place, there is practically no disability, with but mild and easily controlled symptoms. Poor are those in whom continuation of symptoms has produced a severe degree of disability or complications.

In the cases treated the results of treatment in my series were good in 54 per cent, in 38 per cent fair, and poor or operated upon in 8 per cent. Even this 8 per cent were a varying lot.

It serves no purpose to classify the cases as left sided, right sided or entire colon, or in duration of the disease or ages of the patients. Of interest here is that the younger the patient the more often the disease is serious and the older the patient the easier it is to control. Also, in the vast majority of the patients the disease begins in the lower left colon and when confined to this area ulcerative colitis is easier to control. The disease should be classified as primarily mucosal or lymphatic. The lymphatic cases are those in which the lymph structures are deeply involved early, and the most difficult to control, and comprise the larger number requiring surgery.

Under proper medical treatment the less severe cases certainly can be gotten in hand easily, practically every one of them. When the profession

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meets the responsibility of better diagnosis and treatment of this disease, the instances requiring surgery will be few indeed.

Of those cases with continued diarrhea and pathology, about two-thirds will be due to chronic ulcerative colitis. As the cases are met with, the entire colon will be involved in about half, and the rectum, sigmoid and descending colon in about one-third. In about one-fifth the process stops at the hepataic flexure or is segmental. In those with short histories or very superficial and moderate involvement, the colon may appear normal and rugal studies for diagnosis are necessary. Often a cured case will show a definite change by x-ray. After years of time, a colon may reconstruct itself enough for it to appear quite normal. In the majority of the cases some degree of the pathologic x-ray picture persists, and according to Ricketts, Kirsner and Palmer [13], regression occurs in approximately only ten per cent.

In the past twenty years the writer has seen 542 cases of chronic ulcerative colitis, non-specific in classification. Of these 161 are left out of consideration for various reasons. The remaining 392 cases were under more or less continued observation and had been treated for a sufficient period to drew some deductions. I desire to repeat that one must keep in mind that the disease is so fickle, experience with the cases so variable, and the results from different items of treatment so unpredictable, the status of disease so difficult to classify, that, even more so that in peptic ulcer, statistics are only of relative value.

Treatment

It is well to begin treatment with the patient in bed which is an essential in the febrile and fulminating cases. The principle of rest brings about physiological reconstruction of depleted bodily functions and mental energies. By continued rest and heat to the abdomen a moderate diminution of the hyperactivity of the colon occurs, somewhat limiting cramps and diarrhea and often doing away with opiates and sedatives. If a start in bed is not practical, it is well to cut out all social activities, house responsibilities, encourage resting, and have a happy and pleasant atmosphere around the patient.

This early stage of treatment is the best time to question the patient on any worries, fears and anxieties, emotional conflicts, maladjustments, etc., and exercise common sense, the teaching of the Bible or Talmud to straighten them out. If the patient requires psychoanalytical treatments it is better not to conduct these when the patient is in bed.

Often intravenous therapy is necessary to overcome dehydration, subnutrition and debility. Only blood and plasma are employed since all the others are only poor substitutes. Intravenous mercurochrome may be employed alternating with the blood and plasma. A recurrence is easily brought about by a respiratory infection.

Diet. No restrictions of nutritious foods should be carried out in treating chronic ulcerative colitis. Two fundamental rules are important. 1. The taking of the largest amount of protein foods possible in order to meet the shotages of nutrition caused by the diarrhea, infection, weight loss, anemia, avitamatosis, etc., to which amino-acid and supplemental feedings are added, but milk is not allowed. Sometimes infusions containing amino acids are employed. Effort should be made to keep the serum protein at the highest possible level.

2. The physical character of all foods be fluid or semi-fluid so as to digest the largest amount in the upper levels of the small intestine and so that one has the smallest amount of residue to collect in the colon.

Allergy. In the majority of cases of ulcerative colitis the history of an allergy to certain foods cannot be obtained. Since milk, eggs and wheat comprise about 90 per cent of the food allergies, these are eliminated at the start of treatment. In my experience, antiallergic diets that are difficult to follow (Rowe and Andresen) are rather unsatisfactory, especially in the ambulatory case. However, there is no objection to employing these eliminating types of diet because of the bland, low residue properties which, in my opinion, account for most of the good effects that have been attributed to them.

Vitamins. Moderately large sized doses were used by mouth and parental injections. Natural B. complex and injections of crude liver answer well. Effort should be made in the diet to employ foods high in vitamins, since natural vitamins are of more value than synthetic ones.

Anti-diarrheal measures may be used to control a large number of movements where these are too distressing. One of the opiate preparations is best used occasionally, but, if possible, rest and sedatives should be tried first. During the course of treatment in all cases and for long periods of time, a teaspoonful of bismuth subgallate is given in water before breakfast, (sometimes also at bedtime) and this may slow down the movements. Occasionally intravenous alimentation maintained for several days puts the bowel at rest.

Vaccine. Vaccines, made of any of the coliform organisms have been most successful in my hands.

It has been brought out that the intestinal bacteria are the infective factor. As has also been brought out, the organisms of greater significance

here are those of the coliform types and that this coliform group comprises forms all the way from the innocent B. coli to the pathogenic and specific forms of B. dysenteriae, B. paradysenteriae, B. typhosus.

The first vaccine used was the B. coli from the patient when this was highly hemolytic. If not highly hemolytic a strain from another source was employed. It was found that as good results could be obtained from a polyvalent B. dysentery vaccine of organisms taken from instances of acute and chronic dysentery. Sometimes the patient's hemolytic B. coli are added to the stock strains of the paradysenteriae in half and half quantities.

Mercurochrome. The intravenous use of mercurochrome was first described by Young and Hill.[14] In the next seven years a number of articles on its use in ulcerative colitis were published by Einhorn,[15] Rosser,[16] Smithies,[17] and Rouse,[18] reporting optimistic results. As time went on it proved to be a dangerous drug in the dose employed. No investigative work was done to standardize the dose and estimate the safety of the drug. In 1927 in a case of streptococcus septicemia, and one of brain abscess in which mercurochrome was used, intravenously, the autopsies were interesting in that the interior of the colons were deeply stained and apparently the colon was an important source of its elimination. Other than the kidneys, the other tissues of the body were not stained.

Its early use in ulcerative colitis was to control the infection in the bowel wall. No means had yet become practical for accomplishing this, but what was of interest was its use to help control the reinfection factor that infects the mucosa from the glands and thus causes the recurrences. In the early days the doses of mercurochrome employed was approximately 0.168 gm for a person 50 kilos in weight. My minimum dose is 2 cc of a 1 per cent (0.02 gm) solution and this raised in the absence of reaction to 5 cc (0.05 gm). In the vast majority of my cases mercurochrome intravenously was employed, alternating with 250 cc blood transfusions one each four days. Several thousand injections have been given without one untoward effect.

Drugs. Usually the patients had been taking sulfa drugs in various forms before I saw them. None of these drugs were curative to any dependable degree in the well established case, even admitting that an occasional case would show some benefit for a short spell. It has been reported that after the oral administration of the non-soluble sulfa drugs there is a decrease of the gram negative and an increase in the gram positive organisms which is not so.

Many of the cases have an achylia or low acidity from a granular gastritis which the colonic infection brings about. One cc of dilute hydrochloric acid in four to eight cc of gastron well diluted and sipped after meals often is of benefit.

There is no objection beginning the treatment with a run of the non-toxic antiamebic drugs (vioform, diodoquin). Their use surprisingly often brings about a rapid improvement in the diarrhea. This temporary benefit occurs in about half of the instances of chronic ulcerative colitis.

Anemia. Hypoproteinemia. These were corrected by 250 cc of blood transfusions given every fourth day and kept up for weeks. Even in the presence of only moderate anemia these transfusions were employed, because there are other constituents in blood then hemoglobin and proteins that are helpful.

Psychotherapy. Since the writer believes that emotional disturbances are not fundamental in the production of ulcerative colitis psychiatric treatment is considered as of little importance generally. The average physician should take an interest in the patient's problems, making corrections and giving advice so as to bring about adjustments. When the patient was well enough a few questions were asked at various times on matters of personal faults, domestic, family or financial difficulties, etc., and advice given.

Surgery. Chronic ulcerative colitis is a medical disease and should be treated medically as long as there is any hope for improvement. Recovery is slow and it must be remembered that it is a young person's disease (average 28 years). If you can keep these people living long enough, time will benefit and often cure the disease. There is no disease in medicine in which the patient can reach such a state of emaciation, debility and illness and yet recover. The decision for surgery carries much responsibility and should be made by an experienced person. There also is no disease in which operative statistics vary so markedly. Considering mortality and the unhappiness of an ileostomy or cecostomy, one usually is influenced against operating upon these cases early. There are, however, certain criteria that serve as guides. These may be said to be:

I. Where the disease has existed for a length of time without substantial benefit, and general health is failing in spite of good medical handling and a conscientious patient. Cattell[19] reports that about one-quarter of the cases at the Lahey Clinic are operated upon.

II. Perforation, which occurs very infrequently.

III. A long history of hemorrhaging from the bowel with continued diarrhea.

IV. Internal and multiple external fistulae of the rectum.

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V. Strictured state too high for manual divulsion. Those in the rectum usually can be controlled.

VI. Malignant disease.

Cattell[19] stated an ileostomy is not a cure, and it may be asked if the removal of an organ (colon) can be designated as a cure.

Carcinoma in chronic ulcerative colitis is reported from 1.9 to 7 per cent. While carcinoma may develop from the inflammatory pseudopolyps of ulcerative colitis it is rare. In my cases followed over ten years it occurred in three instances (1 per cent). Polyposis accompanying chronic ulceratative colitis is generally accepted as the designation of a bad case and one in which colectomy is advisable. There were many instances in which the symptoms have abated and the patient got along well even though the polyposis persisted. If fistulae are in the lower rectum and the condition is active, local surgery is not advised without a preliminary colostomy or ileostomy.

The question of surgery should be left quite up to the personal equation of the individual. If the person is reasonably in control of the condition, able to be fairly active up and around, work, etc., I advise conservatism.

There are people who would rather commit suicide than carry an ileostomy, and others who don't mind them at all. Some even are so satisfied that they will not agree to a reconstruction operating making possible the elimination of the ileostomy bag. So the percentage of cases in which major surgery is recommended is variable. In my practice it is about 5 per cent (appendicostomies not included) and usually performed for complications.

I here would like to present the use of appendicostomy (cecostomies) with irrigations. Appendicostomy has been discarded and it should be reestablished and be popular as an addition to the medical handling of chronic ulcerative colitis. An appendicostomy is a very minor surgical operation and can do no harm if it does not good. It is not inconvenient to the patient and when properly performed has no drawbacks connected with it (such as leakage, closure, etc.) What I observe today in handling chronic ulcerative colitis is a relatively poor effort at diagnosis and medical treatment and then a jump to ileostomy, colectomy and perhaps removal of the rectum. What would be better is more assiduous medical attention, and appendicostomy, if after a reasonable time, improvement is not manifest solely on medical treatment, and then finally the major surgery if all else fails. On the whole appendicostomy (cecostomy) has been performed 32 times and only four required more serious surgery after that. It does no harm and one should not be in a hurry to close it. Should further surgery be necessary the small appendicostomy opening would not interfere. After the ileostomy if colonic irigations are introduced from the cecum (by way of appendicostomy or distal stoma of the ileostomy) the number of final ileosigmoidostomies would be increased.

At the A.M.A. meeting of 1947 two opposite points of view were expressed. Bargen was of the opinion that the condition should be judged as a medical one, operations not being in order, and Leahy stated that operations should be performed more often and earlier. My own point of view is that a general statement is not important, and the only thing of value is the wisest judgment in the individual case.

I agree with Bargen and Paulson that intractability depends on the skill and perserverance of the medical advisor and the man managing the disease. When these are satisfactory, ulcerative colitis will be found to be a disease that is curable and controllable to a high percentage by medical means, and cases so handled will leave but few cases for operation.

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BILATERAL NON-SIMULTANEOUS FEMORAL ARTERIAL EMBOLIC OCCLUSION

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THIS CASE is being reported for two reasons. (1) It would appear to be relatively rare. (2) It serves as a vehicle whereby we may reiterate and emphasize some of the known scientific medical facts about peripheral arterial embolism allowing us to explore some of our own experience and possibly to draw conclusions therefrom.

Case Report

Mrs. F. B. aged 79, a white, widowed female, was admitted to the Jane Brown Memorial Hospital on June 18th, 1946. Her chief complaint was gas on the stomach and pressure against her heart. Three years ago she had a thyroidectomy for hyperthyroidism from which she has recovered nicely. During the past few years she has noticed increasing dyspnea on exertion, orthopnea and occasional ankle edema. She has had a dry chronic cough for fifteen years which has occasionally come in spasms. For the past three or four days she has noticed more gas and belching than usual. Yesterday she described the gas as moving up into her chest, and she developed an ache under the sternum with shortness of breath; no radiation of pain. She became nauseated and has vomited twice. Dizziness developed so she found it difficult to get out of bed. Physical examination revealed a few fine rales at both bases. The heart rhythm was grossly irregular with a bigeminal quality, no murmurs, sounds of poor character, no friction rub. Blood pressure 90/50. There was slight distention of the neck veins. The abdomen was softly distended with gas. The liver was palpable one and one-half fingers below the costal margin; no tenderness. There was one plus edema of left ankle. Impression: Coronary occlusion. Electrocardiogram showed a slow auricular fibrillation with a ventricular extrasystole after each normal ventricular complex. An E. K. G. taken three years ago also showed auricular fibrillation.

She was treated with Digitalis, Quinidine, Codeine and nasal oxygen as indicated, and seemed to be doing surprisingly well. Suddenly at 11:30 a.m. June 24, her sixth hospital day, she complained of numbness in her right leg, and this became cyanotic, blotchy and cold. She rang immediately for her nurse who instantly recognized that a serious situation had arisen, and promptly called her physician. He responded within twenty-five minutes and made a diagnosis of acute arterial embolic occlusion to the right lower extremity. Twenty minutes later I saw the patient, and at that time the right leg was cyanotic to the midthigh where a line of demarcation was present. The patient was dyspneic, orthopneic, anxious, getting nasal oxygen. Examination of the good leg revealed strong pulsations of the femoral, popliteal, posterior tibial and dorsalis pedis arteries. Only a very feeble femoral pulsation could be made out in the right or affected extremity. It gave the impression of a transmitted impulse. A presumptive diagnosis of embolic occlusion to the main femoral artery of the right leg at its branching with the profunda was made. As soon as arrangements could be completed, the patient was removed in her bed, still receiving oxygen, to the operating room and transferred to the operating table still in a sitting up position.

Under one percent local novocaine infiltration anesthesia the right femoral artery was exposed. It was without pulsation and in spasm. It was followed upwards to its branching with the profunda where strong visible pulsations could be seen above. Tapes were placed about the artery above and below, and the artery opened longitudinally in its quiet portion. There was slight back bleeding, no bleeding from above. The embolus could be seen by looking up the artery, and an attempt was made to remove it with suction without success. A Binney type gall bladder clamp was then used and the clot pulled out followed by a spurt of blood that went almost across the room. This was controlled by twisting the tape, and the artery was promptly closed using a continuous suture of five zero fine silk. The superficial femoral vein was then exposed and ligated just below its junction with the profunda. Before ligating, it was opened and free bleeding encountered both from above and below. Pulsations were seen to be pres-

continued on next page

ent in the artery, and the leg, immediately following operation, was seen to have lost its cyanotic, mottled appearance. The numbness and pain disappeared immediately, and the patient could again move her leg. A faint pulsation could be made out in the right popliteal artery, no pulsation in dorsalis pedis and posterior tibial arteries.

Anticoagulant therapy was instituted starting with Heparin injected into the artery itself at the completion of the embolectomy. In the days that followed the patient had no more serious difficulty with this leg, and to all intents and purposes it was essentially normal.

On June 26, 1946, four days after the original embolic occlusion, a completely similar accident occurred in the opposite lower extremity. At 7:30 a.m. she suddenly developed numbness, pain and coldness in the left lower extremity, exactly similar to what had happened before in the right. She was seen by her physician within three-quarters of an hour who again promptly made the diagnosis of left femoral embolic occlusion. At 9:15 a.m. the patient was again in the operating room undergoing another embolectomy. A similar situation was encountered, and another large embolus removed. Following closure of the artery and superficial femoral vein interruption, all major arteries of the left leg were found to be pulsating down to and including the posterior tibial and dorsalis pedis arteries. The patient had no further trouble from either leg during the remainder of her course in the hospital.

About a week late she began to have chills and attacks of increasing breathlessness which suggested repeated pulmonary infarction. She expired on the thirty-seventh hospital day. Autopsy revealed generalized arteriosclerosis, coronary thrombosis, myodardial infarction, mural thrombus left ventricle and left auricular appendage and right auricular appendage, pulmonary infarction, septic pulmonary infarction. The lower extermities were normal.

Through the courtesy of Dr. Davis and Dr. Moor, surgical chiefs respectively at the Rhode Island Hospital and Pawtucket Memorial Hospital, I have been privileged to inspect the records on the cases of peripheral embolic arterial occlusion to the extremities in these two institutions. This gives an idea of the rarity of the condition and of the type of results that we have been obtaining in this community. It furthermore is a considerable educational privilege to be able to review records of this sort as one cannot help but gain much valuable knowledge from the lessons to be learned in such a study.

In a ten year period there have been nineteen such cases discharged from the Rhode Island Hospital and eight from the Memorial Hospital. It can be seen that the great bulk of cases are in patients over sixty years of age. (See Figure No. 1)

Figure 1.

ARTERIAL EMBOLIC OCCLUSION IN EXTREMITIES

Age distribution
1937-1947

Age	R. I. H.	Mem.
30 to 40	0	1
40 to 50	3	1
50 to 60	3	2
60 to 70	7	3
70 to 80	4	0
Over 80	2	1
Total	19	8

There is a definite preponderance of cases seen in the female sex. This is probably due to the fact that life expectancy is greater in females than it is in males. (See Figure No. 2)

Figure 2.

ARTERIAL EMBOLIC OCCLUSION IN EXTREMITIES

Sex

	Female	Male
R. I. Hospital	10	9
Mem. Hospital	5	3
Percentage	55%	44%

The following arteries were involved, and although this series is small, it would appear that the right femoral artery is more prone to such an accident than the other arteries of the body. (See Figure No. 3)

Figure 3.

ARTERIAL EMBOLIC OCCLUSION IN EXTREMITIES

Artery Involved

	RIH	Mem
L. Popliteal	5	0
Rt. Popliteal	3	1
L. Femoral	4	1
Rt. Femoral	7	4
L. Brachial	1	0
Rt. Brachial	0	1
Rt. Post. Tibial	1	0
L. Iliac	1	1
L. Radial	1	0
Rt. Radial	1	0
L. Axillary	0	1

More than one artery was involved in five patients at the Rhode Island and one patient at the Memorial. (See Figure No. 4)

Figure 4.

ARTERIAL EMBOLIC OCCLUSION IN EXTREMITIES

Pts. with more than one artery involved.

	RIH	Mem.
Cases	5	1
Percentage	26%	13%

Auricular fibrillation was found in a very large percentage of the cases. Coronary thrombosis and rheumatic heart disease was likewise frequently found in association. (See Figure No. 5)

Figure 5.

ARTERIAL EMBOLIC OCCLUSION IN EXTREMITIES

Associated Cardiac Conditions

	RIH	Mem
Auricular Fibrill.	17	3
Coronary Thrombo.	5	2
Rheumatic Heart Dis.	0	2

Approximately two-thirds of these patients come to some form of surgery before their discharge from the hospital. This is largely divided into embolectomies and amputations. (See Figure No. 6)

Figure 6.

ARTERIAL EMBOLIC OCCLUSION IN EXTREMITIES

Operations

	RIH	Mem	%
Embolectomies	5	2	25
Amputations	6	4	37

Total no. ops. 17

One patient at RIH had a cerebral accident during op. and died next day. One patient at Mem. refused amputation.

Other adjuncts to surgical therapy which have been used in this community are anticoagulant therapy, intermittent venous occlusion or the Pavex boot, sympathetic novocaine blocks, papaverine, ice.

The mortality in these cases is high, eight such patients dying at the Rhode Island Hospital and five at the Memorial. (See Figure No. 7)

Figure 7.

ARTERIAL EMBOLIC OCCLUSION IN EXTREMITIES

Mortality

	Deaths	Percentage
RIH	8	42%
Mem.	5	62%

From this study I suggest the following conclusions: 1. Peripheral embolic arterial occlusion is a surgical emergency of the very first order. Time is of the essence, it merits consideration in the same category as internal hemorrhage, acute perforation of an abdominal viscus, a compound fracture. Other examples could be given ad infinitum. Any sudden pain developing in an extremity, regardless of the hour of the day or night, should be promptly seen and diagnosed. Embolectomy, where indicated, should be done under six hours for the best result. Anything over twelve hours invites disaster. Amputation is an operation of the first magnitude in these cases. Embolectomy is a relatively minor procedure, easy of performance in skilled hands, taking little or nothing out of the patient. 2. The diagnosis of these conditions is relatively simple. All one needs to do is to become as acquainted with the femoral, popliteal, posterior tibial and dorsalis pedis pulsations as one is with the radial pulsation. All patients over the age of fifty that are admitted to a hospital should have on the record an indication of what the arterial status is in both lower extremities. It would be a good routine if our nurses were instructed in the taking of a femoral, popliteal, posterior tibial and dorsalis pedis pulsation on all patients so that they would become vascular conscious and promptly recognize changes in the circulation. We, as physicians, should familiarize ourselves with these pulsations in the normal so that we can more readily recognize them in the abnormal. 3. Patients with auricular fibrillation and coronary thrombosis should be particularly suspect of developing this condition, and should be appropriately watched and warned. 4. It is always more desirable to have a normally functioning artery than to have one which is occluded. This means that wherever possible the embolus should be removed. In some instances where vigorous early medical therapy is instituted including anticoagulant therapy, sympathetic blocks, papaverine and so forth, the extremity may be saved, but it is crippled, never again as normal as extremity with anything short of complete restoration of the arterial circulation. Arterial cripples are pathetic subjects always limited in their activities, subject to claudication and pain, and the future threat of gangrene, together with eventual amputation, if not loss of life.

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SURGERY IN GERMANY

The medical teaching mission to Munich, Germany came in contact with three sharply disassociated groups. These were the American Army, the hospitals for displaced persons, and the German civilian hospitals. There really was no striking difference between the latter two. We did our work at the Altersheim Hospital. As the name suggests, it had been an old folks home and it lent itself readily to its new function. It was a large hospital with many hundreds of beds.

Next door to it across the street from where we lived was the 98th General Hospital of the American Army. This was an enormous place; a pavilion type of construction such as can be seen at the Peter Bent Brigham Hospital in Boston. The staff of this hospital impressed us as being remarkably high in quality. Lieutenant Colonel Preston was Chief of Medicine, Major Westhazen, formerly of the Massachusetts General Hospital, was Chief of Surgery, and Captain Sosman was Pathologist. He is son of the well-known Radiologist of Boston. I took on several different occasions my surgical group to this hospital where we had demonstrations of surgery and anesthesia.

Neither the D. P. nor civilian German hospitals have mechanical apparatus for anesthesia. They use ether, regional, spinal and some intravenous anesthesia. I demonstrated to the class how to make a Miller cone. I still believe that is superior to the open drop method which is in such common use. I saw a number of gastrectomies, appendectomies and thyroidectomies done under local anesthesia. Patients in war torn Europe do not expect their sensibilities to be catered to as is done in America. I think a number of these students were suffering a great deal of discomfort during the operation.

Aseptic technique in Munich struck us as strange. A surgeon never put his gloves on until he had done his injections for local anesthesia. The Sister in charge of instruments frequently did not put her gloves on until the operation was well under way. At the University Hospital all of the surgeons in the operation changed their gloves four times while doing a thyroidectomy. I could not help thinking that the exterior of the gloves could be easily cleansed had they been kept on, while it seemed to me certain that perspiration from the hands must necessarily have got into the operation.

They evidently had great faith in tincture of iodine as they were continually wiping with it such places as the appendix stump, the cut edge of the stomach, etc. I was told in my early days that iodine was to be used only on dry surfaces. However, a lot of aseptic technique seems far from logical. For instance, in the Army Hospital we all had to tie clean cotton cloths over our street shoes before we went into the operation. That is all well enough but I counted at least six of the Army personnel who did not have cotton cloths over their shoes. In our own Altersheim Hospital we always wore caps and gowns in the operating room. At both the University Clinic and at a large orthopedic hospital, a group of us were ushered into the operating room minus caps and gowns.

I was impressed with the fact that German surgeons were proud of their small incisions. I have heard Dr. Lahey quoted to the effect that in his travels about the United States he has noticed that many surgeons have trouble because they do not allow themselves enough room to work comfortably and to see clearly what they are dealing with. Somebody quoted to me in Munich what I suppose is an old aphorism, "the bigger the surgeon the bigger the incision". On an evening early in our stay we showed the class a movie of a thyroidectomy at the Lahey Clinic. Some of the surgeons were critical because the string muscles were clamped and cut. They felt that was brutalizing the tissues. I watched a skillful German surgeon do the same operation without cutting the string muscles, and I thought the pulling and hauling at the attempt to get exposure was more traumatizing; and they didn't get exposure.

Nevertheless, most of the surgeons I watched had great technical skill. I saw a number of gastrectomies done in an hour and a half each. My only criticism was that I think American surgeons are more liberal in the amount of stomach they remove. As I understood that they did not have a good supply of instruments and apparatus, I was interested to see that two different hospitals used the elaborate machine for closing the opening in the stomach with metal clips. On one occasion at least the machine failed. The clips had to be removed and the sewing done by hand.

Our figures show a proportion of something like eight duodenal ulcers to one gastric ulcer. Over there we were told that the propotion was about 50-50. And, in fact, every case of peptic ulcer that I saw operated upon was gastric. However, at least one of these so-called gastric ulcers turned out to be malignant. I know of no vagotomies being done in our neighborhood, but I met a surgeon from Vienna who told me that he had done 125 abdominal vagotomies. They had no apparatus for giving positive pressure anesthesia and hence did no transthoracic operations. This surgeon felt that he was getting excellent results with this operation in case of peptic ulcer.

I was not so much impressed with the traumatic surgery that I saw. In a beautiful orthopedic hospital they were doing a slide bone graft for an ununited fracture of the tibia. As I watched the manipulations I felt that they were not dealing with an un-united fracture. In fact I thought that there was evidence of quite a fair degree of union. What disturbed me in this case was that there were ten of us watching a bone operation and not one of us had a mask on. At our own hospital there were a number of cases that were definitely un-united fractures. They were fixing these by means of a long steel rod driven longitudely along the shaft of the bone through the marrow of both fragments. Of course only time will tell what their results will be, but there seems to me room for much skepticism.

One Munich surgeon is doing a great deal of cineplastic work on amputation stumps. For those of our readers who are more interested in the higher mental realms of medicine rather than the mechanical aspects of surgery, I would explain that this consists in forming skin lined tunnels through the muscles in order that these muscles may be used to manipulate artificial fingers. This work is ingenious and spectacular. How much it adds to the value of prosthetic apparatus for every day work seems problematical.

The thing that surprised me was that they very decidedly were not using early ambulation. I would say in fact that they were keeping their patients in bed much longer that we did ten or fifteen years ago. This probably is due to the poor living conditions which certainly exist in all the camps for displaced persons and probably to a minor extent in most German homes. It must be extremely difficult or often impossible to give reasonable home care to post-operative patients.

Intravenous fluids were used almost not at all. The technique of venepuncture so highly developed in America has been neglected in Europe. However, they did use plasma to a fair extent. This plasma is furnished by the Red Cross. They were not accustomed to using blood transfusions. This may be somewhat due to the fact that people are under nourished and have until recently been somewhat anemic and had no good blood donors. However, I have a suspicion that the struggles for existence has been so bitter that every one per force has had to look out for himself and it has not been possible for them to develop an organized altruism.

Like Dr. Brunschweig who visited Vienna last year, I have felt that on the whole they were getting along better without these aids than probably most of our over enthusiastic therapeutists in this country would think possible.

THE BLUE CROSS — BLUE SHIELD MERGER

As this is written the Blue Cross-Blue Shield Commissions are meeting at French Lick, Indiana, to vote on proposals which include one for the creation of a national voluntary insurance company under their supervision. The proposal was advanced in a 68-page brochure issued by the Commissions to a limited group — the presidents, governing board and executive directors of all Blue Cross and Blue Shield Plans.

Few, if any, county or state medical societies had an opportunity to study the proposal. No copy was sent to any officers of the Rhode Island Medical Society, or to any of the district societies in this State. Perhaps we would be excluded anyway because we have adopted a surgical prepayment plan that is not *exclusively* non-profit in all its ramifications.

The Council on Medical Service of the American Medical Association has issued a lengthy report (which has had the endorsement of the Board of Trustees of the AMA) calling for postponement of the proposition until the House of Delegates can consider it. If this request is not heeded by the administrators of the Blue Cross-Blue Shield Plans, then the entire voluntary movement for health care will be seriously jeopardized.

What is back of this proposal for a national insurance company? Several reasons have been advanced. Some persons charge that a small group of insiders in the voluntary movement are seeking to take over complete control, and these insiders are said to be for the most part non-medical men. The action of the American Medical Care Plans (AMCP), the national organization of Blue Shield programs, in breaking away from the AMA after that body had started it with a $25,000 grant which was repaid this year, is offered as evidence that this theory has some justification.

Doctor Paul R. Hawley, chief officer of the Blue Cross-Blue Shield Commissions, argues that organized labor demands free or subsidized medical care on its terms, and unless its demands are met the present system of medical care will disappear in the maw of a compulsory federal program. A voluntary national insurance company, therefore, would consolidate the programs in all the States, and thereby provide a uniform coverage. But what happens if the single insurance program, which would seek to usurp private insurance in the health and accident field, fails? Would the public discard the entire proposition, or would the federal government move into the picture to replace the voluntary system with a compulsory one? The answer is self-evident.

Organized labor, so-called, will go along with the Blue Cross-Blue Shield Plan for a national voluntary insurance company but it won't compromise on that solution as a final one. Have no doubts about that. Harry Becker, social security director for the United Automobile Workers-CIO, and formerly president of the Group Health Association of Washington, D. C., said after the National Health Assembly this past May that

> "Voluntary plans are good, but by themselves they are not adequate....."
> "The Labor and other consumer groups cannot compromise on the basic question: a public program for all of the people....."

It is true that many of the social security provisions are the result of union contracts. But industry is called upon to pay all or the major portion of the bill.

Becker's own union, the UAW-CIO, has just negotiated a new social security program that provides hospitalization for the worker and his family, income maintenance benefits during periods of lost time for reason of sickness or accident, death benefits, and surgical allowances, *all financed entirely by the employer*. In Rhode Island, industry — not labor — meets nearly all the cost of employee hospitalization provided through Blue Cross, and industry is now accepting the added cost of surgical insurance under our Society's program.

Industry, then, not labor, has the responsibility to provide the adequate coverage it has agreed to pay for, and by whatever insurance program it individually prefers.

Would Doctor Hawley and his Blue Commissions evaluate the future progress of voluntary prepaid health insurance only on the basis of the demands of labor leaders? Has industry, the employee, the medical profession, no rights in the matter?

DISTRICT MEDICAL SOCIETY MEMBERS

KENT COUNTY MEDICAL SOCIETY

The first Fall meeting of the Kent County Medical Society was held the evening of September 14, 1948, at the Showboat, Tiogue Lake, Rhode Island.

The subject of insurance examinations and current fees for the same, recently endorsed by the Committee on Economics of the State Medical Society was discussed. All members present were agreed that the recently adopted schedule was more adequate and compensible to present day standards. It was moved and accepted that future statements to Insurance Companies re Life, Health or Accident examinations be made as suggested by the Committee on Medical Economics; it was further carried that should any difficulties with this policy arise the same should be reported by the individual physician concerned to the society for appropriate action.

Dr. Vidal, Society President, noted that she had received notification from Mayor Albert P. Ruerat, Warwick, R. I. that a library of several hundred books had been donated the Kent County Memorial Hospital by Dr. Ralph F. P. Lockwood of Warwick. Appreciation of this generous gift was expressed by those present; it was decided that these volumes should remain in the custody of the Warwick Mayor and Board of Trustees until the hospital is erected.

Correspondence re the Catherine A. Miller Trust from the Title Guarantee and Trust Company, New York was brought to the attention of members. It was decided to place this material in the hands of the Corporation Attorney, George Roche.

Following suggestions of the State Medical Group formation of a Public Relations Committee by the Kent County Society was discussed. The usefulness of such a committee being recognized, it was agreed by motion and endorsement that the present executive also function as Public Relations representative.

Dr. Edmund T. Hackman, Warwick Health Officer, commented on the city wide chest survey now being undertaken in that area. A motion was made by Dr. Rocco Abbate that this Society commend and endorse the Warwick Health Department's efforts in this community project.

Dr. Arthur E. Hardy requested preparation for discussion at the next meeting, the clarification of direct and associate memberships in the Kent County Medical Society.

Dr. Charles Ashworth, Department of Surgery, Rhode Island Hospital, gave the evening's address. His topic, CARCINOMA OF THE STOMACH, extremely appropriate currently, was very ably handled and held everyone with considerable interest.

The meeting was brought to adjournment at 11 p.m.

Respectfully submitted,

F. D. LAMB, M.D., *Secretary*

* * * *

The October meeting of the Kent County Medical Society was held at the Frog Farm, Warwick, Rhode Island, Tuesday, October 19, 1948.

This was the first combined meeting of physicians and dentists of Kent County. It is intended that such a gathering shall be held annually, primarily for the discussion and solution of mutual problems.

Dr. Vidal, Society president, called the meeting to order at 9:30 p.m. The question of associate membership in this Society was again considered and final settlement shall be effected at the next meeting.

The purpose and function of Medical Public Relations Committees was outlined by Dr. Vidal. Particular emphasis was placed upon cooperating to the greatest possible degree with a local and favorably-inclined press.

Request to provide a medical speaker for the coming senior assembly at West Warwick High School was made by the school principal. Dr. Peter Erinakes accepted this assignment.

Dr. Vincent Ryan, dermatologist from Providence was the evening speaker. He very ably presented a discussion of "Lesions of the Oral Mucous Membranes".

The meeting adjourned at 11:30 p.m.

Respectfully submitted,

FRANCIS D. LAMB, M.D., *Secretary*

NEWPORT COUNTY MEDICAL SOCIETY

The Fall meeting of the Newport County Medical Society was held at the Newport Hospital on Tuesday evening, September 28, 1948 with nineteen members attending.

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NEWPORT COUNTY SOCIETY

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Dr. Philomen P. Ciarla, President, called the meeting to order at 9:05 p.m.

Mr. Lawton from the New England Telephone and Telegraph Company explained the function, installation, and costs of a Doctors' Exchange switch board stating that a 20 plug board could be installed and ready in about six months at a cost of $23.00 per month for the board and $3.00 per month charge for each doctor's line attached to the board.

Old Business: Dr. Samuel Adelson reported that the Annual Meeting of the Rhode Island Medical Society will not be held here in Newport next year because the building facilities here are not adequate for such a meeting. Dr. Adelson suggested that Dr. Michael Sullivan be recommended to the State Society for the General Practitioners' Award. Dr. Louis Burns nominated Dr. Sullivan and this was seconded by Dr. John Malone. Dr. Adelson was appointed a committee of one to submit material on Dr. Sullivan to the State Society.

New Business: Dr. Frank Logler moved that the County Society approve to cooperate with the National Red Cross in its program to set up Blood banks and moved that a committee be appointed to work with the Red Cross if and when the opportunity arises to have a blood program in this locality. The motion was seconded and approved. Dr. George Eckert was made chariman of this committee — other members were Drs. Norbert Zielinski, Burns, Logler, and Mayner.

Our guest speaker, Dr. Jesse P. Eddy, 3rd, of Providence, gave a very instructive talk entitled "Sympathectomy and its Role in the Treatment of Vascular Disease." This lecture was illustrated by lantern slides. A patient with severe Buergers Disease was presented. Dr. Eddy had recently sympathectomized all extremities of this patient with the result that the patient was completely relieved of symptoms and showed almost complete healing of his fingers and toes which previously were gangrenous.

The meeting adjourned at 10:50 p.m. Collation served.

Respectfully submitted,

JOHN M. MALONE, M.D., *Secretary*

PAWTUCKET MEDICAL ASSOCIATION

The regular monthly meeting of the Pawtucket Medical Association was called to order by the President, Dr. Earl Mara, at noon, September 23, 1948 in the Nurses Auditorium of Memorial Hospital.

It was moved by Dr. Duncan Ferguson that the committee which wrote the articles in rebuttal to the series in the Providence Evening Bulletin concerning Medical Care be commended and that the secretary make appropriate mention in the records. This motion was passed.

The following physicians were elected to membership in the Association:

Dr. Robert Clement Hayes
Dr. Alice Madros Kechijian Bandeian
Dr. Edward Damarjian — Associate membership

Dr. Charles Farrell discussed a radio program arranged by the Public Relations Committee of the Rhode Island Medical Society and by a majority vote it was decided that the Pawtucket Medical Association would sponsor this program through local stations.

A film, "The Treatment of Trichmonas Infection," was then presented, at the conclusion of which the meeting was adjourned.

Twenty-three members attended.

PROVIDENCE MEDICAL ASSOCIATION

A regular meeting of the Providence Medical Association was held at the Medical Library on Monday, October 4, 1948.

Prior to the meeting Dr. Philip Batchelder, President of the Association, presided with Dr. Joseph C. O'Connell, President of the Rhode Island Medical Society, at exercises held in the

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lower hall and reading room for the dedication of a memorial tablet erected by the Rhode Island Medical Society in memory of four members who died while in the service of the armed forces during World War II.

The regular meeting of the Association was called to order by the President at 8:50 p.m. in the Library auditorium. The reading of the minutes of the previous meeting was omitted by general consent.

The Secretary read a communication from the Secretary of the Rhode Island Medical Society, noting in particular the following items:

The Cancer Committee of the State Society, with cooperation from the Rhode Island Cancer Society and the State Department of Health, will hold an all day Cancer Conference for physicans at the Medical Library on Wednesday, November 17, 1948.

The Committee on Medical Defense asks that each district society again call to the attention of its members the importance of having liability insurance as a protection in threatened malpractice suits. Complete information on such insurance can be secured by communicating with the Executive Office.

The House of Delegates has voted to hold the annual meeting of the Society in 1949 at the Medical Library in Providence, on Wednesday, May 11, and Thursday, May 12. Members are asked to check these days far in advance in order to keep them free to allow attendance at the 138th Annual Assembly of the Society.

At a meeting of the House of Delegates on September 29th a budget almost indentical to that for the current year was approved for the continued operation of the Society and the Library during 1949. At the same time the House of Delegates set as the dues for 1949 for Fellows in practice more than one year, $40 payable quarterly if a Fellow so desires, and for Fellows in their first year of practice, $25.

After a report by Dr. Joseph O'Connell, president of the Society, relative to his visit to Washington during the summer to discuss the problem of staffing the Veterans Hospital at Providence with U. S. Veterans Administration and a Congressional group, the House of Delegates unanimously adopted a resolution for transmission to the Veterans Administration.

The House of Delegates has voted that every Fellow of the Society shall receive a letter restating the previous action of the House relative to fees for physical examinations for insurance companies, and calling attention to the fact that this action is official action by the Society which should be respected by every Fellow until such time as the action is altered or rescinded.

The Secretary reported for the Executive Committee as follows: The Executive Committee agreed that if the Rhode Island Medical Society should arrange to have a mid-winter meeting outside the City of Providence, and a joint meeting with this Association as has been the policy in recent years, that the regular February meeting of the Association would be held on whatever date is determined for the joint meeting by the State Society.

The Executive Committee authorized the President of the Association to appoint a committee to re-open the study relative to a central telephone exchange under the control of the Association.

The President announced as follows: That the Annual Dinner and Golf Tournament of the Association would be held at the Agawam Hunt Club on Wednesday, October 20 and that a splendid program was being arranged by the Chairman of the Committee, Dr. Herman P. Grossman.

That the obituary committee of Dr. Albert H. Miller and Dr. Robert H. Whitmarsh has prepared and has submitted for the Association's records a tribute to the late Dr. John A. Hayward.

That to fill vacancies on the Executive Committee of the Association he had named Dr. Alfred L. Potter, Dr. Louis Kramer, and Dr. E. Victor Conrad to the Committee; and he had also named Drs. Potter and Conrad as Delegates to the House of Delegates of Rhode Island Medical Society to fill vacancies to that body from this Association.

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P M A GOLF WINNERS

The annual dinner and golf tournament of the Providence Medical Association was held at the Agawam Hunt Club, Rumford, on October 20. Winner of the President's trophy, awarded by Dr. Philip Batchelder, was Dr. W. J. H. Fischer who scored the low gross of 77.

Other winners were: 2nd low gross, Dr. Frank Cutts (84); low net, tie between Dr. Clarence J. Riley and Dr. Benedict Chapas, each of whom scored 68; second low net, tie between Dr. Clifton B. Leech and Dr. Robert Riemer, both of whom turned in 69's; guest prize, low gross, to H. French (87), and low net, Dr. Kenneth T. Moore, (69) formerly of Providence and now a resident of Hanover, Mass.

Ninety members of the Association and guests attended the dinner in the evening. A program of entertainment was provided by the committee of the Association headed by Dr. Herman P. Grossman.

PROVIDENCE MEDICAL ASSOCIATION

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Dr. Daniel V. Troppoli reported that the Executive Committee recommended for election to active membership in the Association the following:

Walter E. Campbell, M.D., Earle F. Cohen, M.D., Henry B. Fletcher, M.D., Frank Giunta, M.D., James F. Hardiman, M.D., Alfred Kant, M.D., John Roque, M.D., Milton G. Ross, M.D., George H. Taft, M.D.

The motion was made, seconded and unanimously adopted that these physicians be elected to active membership in the Providence Medical Association.

Dr. Batchelder stated that Dr. James J. Scanlan, an intern at St. Joseph's Hospital, has submitted a case report for competition in the Association's Prize Case Report Contest and that he would now present the case to the Association. Dr. Scanlan presented a case on "MYXEDEMA AND PSYCHOSIS".

Myxedema is due to endocrine dysfunction and is amenable to cure. Symptoms of asthenia and lethargy set in followed by puffiness and inability to concentrate on figures while at work.

In his case these symptoms were followed by hallucinations of persecution and delirium. She has typical facies, low metabolism, and a cholesterel of 240. On treatment with thyroid extract, patient's condition returned to normal and psychosis disappeared.

The president introduced Dr. Robert W. Riemer, Surgical Resident at R. I. Hospital who discussed: "UTERINE APOPLEXY WITH RENAL INSUFFICIENCY". The discussants were Drs. Landsteiner and DiLeone.

Dr. Riemer presented three cases of uterine bleeding with renal insufficiency. Acute renal insufficiency following shock is frequently seen especially during the War. This renal insufficiency was first described by the British in 1941 as seen in the crush syndrone.

The same condition is seen in burns, hemolytic reactions, sulfa intoxications, and they all have the common feature of destruction of tissue. Following shock a period of oliguria and anuria sets in which if prolonged may result in death. Pathologically, we find large pale swollen kidneys. The damage is tubular with no disturbance of the glomeruli or the proximal tubules.

Thirty-six to seventy-two hours after injury, we get precipitation of pigment in the distal convoluted tubules and in the collecting tubules. The term lower nephron nephrosis is applied to this condition.

These patients developed oliguria, hemoglobinemia, and azotemia. Mallory showed that hemoconcentration by hematocrit sets in before clinical finding show up.

During the oliguric stage, patient is treated by limitation of fluids to 1000 cc D/W. After the diuresis sets in, saline is given. Careful check of blood chlorides is done. It is in this phase that a lot of salt is lost in the urine and patients die if saline is not given. One case was also treated with continuous spinal anaesthesia. What effect this had was hard to evaluate since Luke showed that spontaneous diuresis occurs in the seventh to the tenth day anyway.

Dr. Landsteiner in discussing the paper stressed the loss of salt through diminished intake, loss through gastric juices, and by increased plasma volume diluting the chlorides. He also stated that acidosis sets in.

In treating the oliguric phase, in addition to fluid and salt restriction, he advised small quantities of blood, amphojel to combat high phosphate level, and continuous gastric lavage.

Dr. DiLeone in the discussion stressed the similarity of the crush syndrone to partial separation of the placenta. He stated that renal insufficiency can also occur in prolonged labor.

The final presentation of the evening was by Dr. Stanley A. Wilson, Roentgenologist at the Salem (Massachusetts) Hospital, who spoke on "PULMONARY CHANGES OCCURRING IN BERYLLIUM WORKERS". The discussant was Dr. Ham.

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THROUGH . . . the Microscope

Cash Sickness Compensation Now that the elections are over, and the legislators are assured of their offices for two years at least, you may look for the introduction of much legislation in the coming year, and then possibly a retrenchment in the policy the second year as the controversial issues at the state level are avoided. One phase of legislation that will probably come in for plenty of discussion in the next year will be that of cash sickness compensation acts.

Three states, Rhode Island, California, and New Jersey, now have such programs, with Rhode Island's the only one that is a state monopoly. The others allow competition by insurance companies against the plan offered by the State. Perhaps Rhode Island should give some thought to such an approach, rather than take the attitude that its program is letter perfect. Patching it here and there to meet annual criticisms doesn't seem to improve the plan any.

* * *

Where Does GP End? In August the district court in the State of California handed down a decision on a malpractice case which promises to evoke a great deal of discussion in medical circles. The ruling was, in effect, that a general practitioner in a locality where there are medical specialists is legally liable if he, lacking the skill and learning of the specialist, undertakes a specialized procedure.

The case had its start when a physician in Lodi (Cal.) engaged in general practice undertook the treatment of a 62 year old male who had been injured in an accident in which he sustained a double comminuted fracture of the lower left leg, one of the fractures being compounded. The hospitalized patient was treated by a physician who, after x-rays, etc., decided against the use of any traction on the leg.

The patient sued the physician, testifying that because of atrophy of the muscles of the leg (Causing it to be shortened 1¼"), and the pain therefrom, he could not place his weight on the leg and required the use of a cane. The defense contended, among other things, that a doctor practising in a city contiguous to a metropolitan area may testify to the standard of care in a city likewise contiguous to the same area, but that where the issue is the standard of care in a rural community a doctor may testify only if he has knowledge of the standard of care in the particular rural community involved.

The court turned down this argument, maintaining that there might have been a proper distinction at one time, there was no longer any basis for such a rule because of rapid transportation and communication. (The nearest orthopedic specialists available in this instance were 12 miles away.)

The court commented that the record showed the general practitioner was confronted with a very unusual situation and there was no emergency, and he undertook to treat a very complicated, difficult and unusual fracture. The court held that in such a case the general practitioner would be negligent if he undertook the treatment, except in an emergency when no more highly skilled physician was available, or unless he disclosed the need of such ability and his lack of it to his patient and the patient nevertheless insisted upon his proceeding. It stated that the general practitioner, and not his patient, is in a better position to know when the specialist is needed.

* * *

Dates to Check Now The House of Delegates of the Rhode Island Medical Society has set Wednesday, May 11, and Thursday, May 12, for the 138 Annual Meeting of the Society at Providence in 1949. The American College of Physicians will conduct its 30th annual session at New York City, March 28 through April 1, 1949.

* * *

A Sea of Red Ink Under this caption *Philadelphia Medicine,* bulletin of the County Medical Society, sounds a warning about hospital deficits. Stating that this year voluntary hospitals

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THROUGH THE MICROSCOPE

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in the five-county Philadelphia area will close their annual fiscal accounts with more than $2-million written in red ink, the journal warns that if such deficits continue ultimate bankruptcy lies ahead because the potential contributor is reluctant to help wipe out a deficit unless he has reason to believe the situation will not happen again. As a warning to hospital adminstrators the journal advises that "before appealing to every possible source of increased revenue, administrators of every hospital would do well to make a detailed and earnest study to eliminate any waste, duplication or inefficiency — an efficiency study such as most large businesses conduct from time to time to keep production costs at a minimum."

* * *

The Supply of Dentists The American Dental Association announced last May that the number of dentists in the United States had increased more than 8,000 since 1940 to a total of 78,490. The breakdown by regions showed in the 1948 survey that there was a dentist for every 1,817 of population in the country; one for every 1,655 in New England; and one for every 1,686 in Rhode Island.

The supply of new dentists, however, from the nation's 39 accredited dental schools reached a new post-war low this year with only 1,713 graduates. And next year the number of graduates will reach a ten-year low of less than 1,500, far below the anticipated loss of approximately 2,000 dentists annually through death and retirement. The upswing will start in 1950 as the large World War II veteran classes begin to complete their postgraduate studies.

* * *

New OB-GYN Board Rulings The American Board of Obstetrics and Gynecology has announced a number of changes in its requirements and regulations. Foremost among the new regulations are those that (1) defines adequate training as meaning a minimum of 6 months, full-time, in the branch of either obstetrics or gynecology relegated to a minor role in a candidate's training and preference for practice; (2) defines acceptable preceptorship training; (3) extends present regulation of at least 6 months of practice in the specialty following the completion of an acceptable training period, to a requirement of 2 years post-training practice limited to the specialty; (4) outlines specific requirements for approval of hospital services for residency training; (5) effective immediately, eliminates temporary approvals of hospital services for residency training.

HOUSE OF DELEGATES
of the
RHODE ISLAND MEDICAL SOCIETY

Report of Meeting Held on September 29, 1948

A MEETING of the House of Delegates of the Rhode Island Medical Society was held at the Medical Library on Wednesday, September 29, 1948. The meeting was called to order at 8:35 p.m. by President Joseph C. O'Connell, M.D. The following Delegates were in attendance,

Officers of Rhode Island Medical Society:
Joseph C. O'Connell, M.D.
Edgar S. Potter, M.D.
Morgan Cutts, M.D.
Charles J. Ashworth, M.D.

Providence Medical Association:
Philip Batchelder, M.D.
J. Murray Beardsley, M.D.
E. Victor Conrad, M.D.
Frank B. Cutts, M.D.
Donald DeNyse, M.D.
David Freedman, M.D.
Russell R. Hunt, M.D.
Albert H. Jackvony, M.D.
Walter S. Jones, M.D.
Herman A. Lawson, M.D.
Edward A. McLaughlin, M.D.
Michael J. O'Connor, M.D.
Daniel V. Troppoli, M.D.
George W. Waterman, M.D.
Frederick A. Webster, M.D.

Washington County:
Julianna R. Tatum, M.D.

Kent County:
Rocco Abbate, M.D.

Newport County:
Louis E. Burns, M.D.

Pawtucket Medical:
Charles L. Farrell, M.D.
Earl J. Mara, M.D.
Louis I. Kramer, M.D.

Also in attendance was Mr. John E. Farrell, Executive Secretary.

REPORT OF THE SECRETARY

Dr. Morgan Cutts, Secretary of the Society, reported as follows:

Since the last meeting of the House of Delegates the Council of the Society has held two meetings to complete the business problems of the Society. A brief summary of the actions taken in major matters is as follows:

War Memorial

The design, purchase and erection of a memorial tablet for the Medical Library to the memory of the four Fellows who died during World War II while on active service was authorized to the Board of Trustees. This tablet has been erected in the lower hall of the Library.

Building Repairs

It was necessary to have the roof ventilators replaced this summer, and the Board of Trustees was authorized to make the expenditure for this work at a cost of $800.

The Editor of the Journal

In the absence from this country of Dr. Peter Pineo Chase, editor-in-chief of the Journal, the Council authorized the appointment of Dr. John E. Donley, associate editor, as acting editor-in-chief.

Annual Meeting Site for 1949

Members of the Council together with the Chairman of the Committee on Arrangements for the Annual Assembly inspected proposed sites in Newport, R. I. for the 1949 meeting in accordance with instructions from the House of Delegates. A recommendation relative to the meeting for 1949 has been adopted by the Council for presentation to the House.

Invitation to Quonset

An invitation from the Commander of the Quonset Air Station to the President and certain other members of the Society to visit the Station and inspect its hospital and medical facilities, and possibly to hold an assembly there, has resulted in the proposal that possibly the mid-winter meeting of the Society might be held at Quonset. This matter is under consideration at this time.

A M A General Practioner Award

The A M A has revised its procedure for the Award of the medal to the outstanding General

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(1) Eisfelder, H. W.: J. Clin. Endocrinol. 2:628, 1942.
(2) Dunn, C. W.: Am. J. Obst. & Gynec. 30:186, 1935.
(3) Grollman, A.: Essentials of Endocrinology, ed. 2. Philadelphia, J. B. Lippincott Company, 1947, p. 574.

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HOUSE OF DELEGATES

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Practitioner as voted by the A M A House of Delegates at its interim session. Hereafter the county societies will submit their candidates to the State Society which will in turn select one representative from the State to be submitted to the A M A. The secretaries of the District Medical Societies in Rhode Island have been informed of this procedure. To pass on any candidate submitted the Council has authorized the President to name a Committee on the General Practitioner Award, to consist of Drs. John F. Kenney, Isaac Gerber, and Elihu S. Wing.

Woman's Auxiliary

A resolution adopted by the A M A House of Delegates urging that State medical societies consider including in their budget the annual national and state society dues so that the wife of each physician might automatically become a member of the Auxiliary, was tabled. It was felt that the Auxiliary should be allowed to run its organization as it deems best.

Emergency Medical Service

The Council has authorized the President of the Society to appoint a committee on Emergency Medical Service to be prepared to meet any program for a national disaster.

Public Relations

The Council has approved of two recommendations from the Committee on Public Policy and Relations. Authorization was given for the chairman of the committee to represent the Society, at its expense, at the national conference on public relations to be held prior to the start of the interim session of the A M A in St. Louis, on November 27.

Secondly, the Council voted to authorize the payment of $78 for the 26 week broadcast of DOCTOR'S ORDERS under the sponsorship of the Society, with the Committee on Public Policy and Relations authorized to handle the program and prepare the spot announcements that will replace the 'commercial announcement' previously included in the program. Approval was also given to allow any district society interested in sponsoring the program in its area to do so, provided it assumes all responsibility for the details of presentation, and the cost.

Society's Budget for 1949

A proposed budget for 1949, almost identical to that of the current year, as presented by the Treasurer, has been approved by the Council. A recommendation relative to this budget, and the dues assessment for 1949 was adopted for presentation to the House of Delegates.

Use of Building by State Cancer Division

A request for possible use of the basement of the medical library building for the temporary housing of the cancer division of the state health department was referred to the Board of Trustees who were empowered to act in the matter.

State Cancer Conference

Approval was given the one day state cancer conference planned by the Cancer Committee of the Society in cooperation with the state cancer society and the State department of health, and the Council authorized the Treasurer to pay the travel expense of out-of-state speakers invited to address the conference.

It was moved and voted that the report be accepted and placed on file.

COMMUNICATIONS

The Secretary reported receipt of a communication from the President of the Providence Medical Association notifying him that Dr. Alfred L. Potter and Dr. E. Victor Conrad had been named as Delegates from the Providence Medical Association to fill the unexpired terms of the late Dr. Patrick I. O'Rourke and the late Dr. Guy W. Wells.

RECOMMENDATIONS FROM THE COUNCIL

The Secretary reported that the Council of the Society presented the following recommendations to the House of Delegates:

The Council, upon hearing the report of the President of his meeting in Washington, D. C., with representatives of Congress and the Veterans Administration, endorsed the action taken by him as the Society's representative, and voted to refer the Providence Veterans Hospital problem to the House of Delegates for its consideration at the September meeting.

* * *

The Council, upon viewing the detailed report of the Treasurer relative to the anticipated expenses for the operation and the maintenance of the Society during 1949, voted to:

A. Approve the budget submitted by the Treasurer for 1949, and to recommend its adoption by the House of Delegates; and

B. To recommend that the annual assessments for 1949 shall be $40 for Fellows in practice more than one year, and $25 for Fellows in their first year of practice in Rhode Island.

* * *

The Council has accepted the report of the Committee on Scientific Work and the Annual Meeting and it recommends to the House of Delegates that the 1949 annual meeting be held in Providence on May 11 and 12.

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HOUSE OF DELEGATES

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The recommendations were briefly discussed and then Dr. Albert H. Jackvony moved the acceptance of all of them by the House of Delegates. The motion was seconded and the recommendations were unanimously adopted.

EXECUTIVE SESSION

Dr. Charles L. Farrell moved that the House go into Executive Session for the hearing of the reports on Public Relations, Veterans Administration Hospital, and the Health Insurance Committee. The motion was seconded and adopted.

Report of the Committe on Public Relations

Dr. Charles L. Farrell, Chairman of the Committee on Public Policy and Relations, read the report of his committee relative to its activities since its election by the House of Delegates in May, 1948. The report is attached to and made a part of these minutes. (Complete report is on file at the executive office for reading by members)

It was moved that the report of the Committee on Public Relations be accepted. The motion was seconded and adopted.

Report of the President on the V A Hospital problem:

Dr. Joseph C. O'Connell, President of the Society, reviewed the developments subsequent to the meeting of the House of Delegates meeting in May relative to the staffing of the Veterans Administration Hospital in Providence. He related as to how he had received a telegram from a member of Congress in Washington requesting him to go to Washington. He did so and there with a Congressional delegation he met with the medical staff of the VA and reviewed the situation regarding the appointment of a Dean's Committee in Rhode Island. He stated that the Society had no objection to the physicians named to the Dean's Committee but felt that the committee should be representative of all the academic colleges in the state and that this might be achieved by adding four additional members of the committee representing Providence College and four representing Rhode Island State College or else name a new committee of six with two representing respectively Brown, Providence College, and Rhode Island State.

Dr. O'Connell also stated that he received the impression from remarks made at the interview that the intern and resident program at the hospital might be started at a later date. He reported how subsequently the Providence newspapers carried a story of his visit and also the announcement that the Veterans Administration would not have an educational program for physicians at the hospital in Providence.

Dr. O'Connell asked for discussion of the problem by the House of Delegates and he reported that he had resolution prepared for possible introduction. He was requested to read the resolution. The resolution is as follows:

WHEREAS the House of Delegates of the Rhode Island Medical Society, assembled in official meeting on January 31, 1946, did resolve that it should endorse the policy outlined by Major General Paul R. Hawley relative to the utilization of the local medical profession for furnishing professional medical personnel for Veterans Administration hospitals, and did also express its desire then and subsequently to cooperate with the Veterans Administration in the operation of the hospital in Providence, proposing that in view of the fact that no medical school exists in Rhode Island the Rhode Island Medical Society be constituted the authority to deal with the Veterans Administration in the matter of nominating physicians to act as senior consultants, consultants, and ward of officers according to the established plan of the Veterans Hospital program, suggesting that consultants be appointed to serve not less than three nor more than six months in each year so that they may still be able to hold positions in civilian hospitals, and suggesting further that the Society be the authority to nominate practicing physicians as they are needed to fill vacancies in the staff of the Veterans Hospital both in its outpatient and in-patient departments, and

WHEREAS the Veterans Administration has seen fit now to reject this cooperation, and has also decided to eliminate a medical teaching program at Providence Veterans Administration Hospital,

THEREFORE, BE IT RESOLVED That the Rhode Island Medical Society hereby repeat its offer to cooperate with the Veterans Administration of the United States to the end that the

veterans of this State and the adjoining State of Massachusetts may be guaranteed the same excellent medical care accorded all the people of this area in the private and public hospitals, and

BE IT FURTHER RESOLVED That the Rhode Island Medical Society urge the U. S. Veterans Administration to reconsider its decision relative to a medical teaching program at the Providence Veterans Hospital, utilizing a medical teaching staff from the medical profession of Rhode Island which now provides such programs at several Rhode Island hospitals to the advantage of the patients and for the important medical training of young physicians of this area.

After discussion of the problem Dr. Abbate moved the adoption of the resolution with the amendment elinimating the names of the hospitals. Dr. O'Connell asked the Executive Secretary to read the resolution adopted by the House of Delegates on January 31, 1946. Mr. Farrell read this resolution. The resolution before the House was then approved.

The question was raised as to whether the resolution just approved by the House of Delegates should be released to the press. Dr. O'Connell recommended that the resolution first be sent to Drs. Magnuson, Carroll and Cushing of the Veterans Administration and then be released to the press.

Remarks by Dr. Lawson

Dr. Lawson claimed the privilege of the floor and stated that he anticipated appointment as Chief of Medical Service at the Providence Veterans Hospital. He reviewed his relations with the Veterans Administration, and voiced his hopes for cooperation from the members of the Society in his assignment at the new hospital in Providence.

Dr. O'Connell congratulated Dr. Lawson on his anticipated assignment as Chief of Medical Service of the new hospital and stated that he felt that he was a physician eminently qualified for the position.

Report of the Health Insurance Committee:

Dr. Rocco Abbate, Chairman of the Committee on Health Insurance read a report of his committee. The report is attached to and made a part of the minutes of this meeting.

Dr. Charles L. Farrell discussed the report briefly. Dr. Troppoli asked if there was any action that the House should take. Dr. Abbate reported that the committee was working out details relative to its problems and there was no need at this time for the House to take any action pending a final report from the committee.

It was moved and adopted that the report on Health Insurance be accepted. The motion was seconded and adopted. (The complete report is on file at the executive office for reading by members)

REPORT OF THE DELEGATE TO THE AMERICAN MEDICAL ASSOCIATION

Dr. Herman A. Lawson, Delegate to the American Medical Association, reported on the meeting of the House of Delegates of that organization at Chicago in June, 1948. He reviewed the action taken on the resolutions introduced from Rhode Island relative to support of the Board of Trustees of the American Medical Association in their purchase of employees insurance through a private insurance company; relative to discrimination against the Rhode Island Surgical Plan by requiring a year's wait before issuing the Seal of Approval; and a criticism of the American Medical Association for failure to make a study of state cash sickness compensation plans.

He reported that the Council on Medical Service had taken cognizance of the resolution regarding the Rhode Island Surgical Plan and as a result the Seal of Approval has now been given to it. He briefly discussed some of the other highlights of the meeting. It was moved that the report of the Delegate be accepted. The motion was seconded and adopted.

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HOUSE OF DELEGATES

concluded from preceding page

QUESTION OF INSURANCE FEES:

In the absence of Dr. William P. Davis, Chairman of the Committee on Medical Economics, the Executive Secretary reported on developments regarding the fees for physical examinations for insurance companies. He reviewed how the House of Delegates had taken action early this year and recommended that the fee for physical examinations for insurance companies, other than for Workmen's Compensation, should be $10.

He reported there had been repercussions from the insurance companies who refused to pay the fee or who dropped from their list some of the physicians who had previously served as medical examiners for them.

Mr. Farrell also reported that the New Jersey Medical Society had been faced with a similar problem and had carried a resolution to the House of Delegates of the American Medical Association in the opinion that the matter could only be settled finally at the national level. The American Medical Association resolution had been referred to the Bureau of Medical Economic Research and Mr. Farrell read a letter from the director of that department stating that it now has the matter under study.

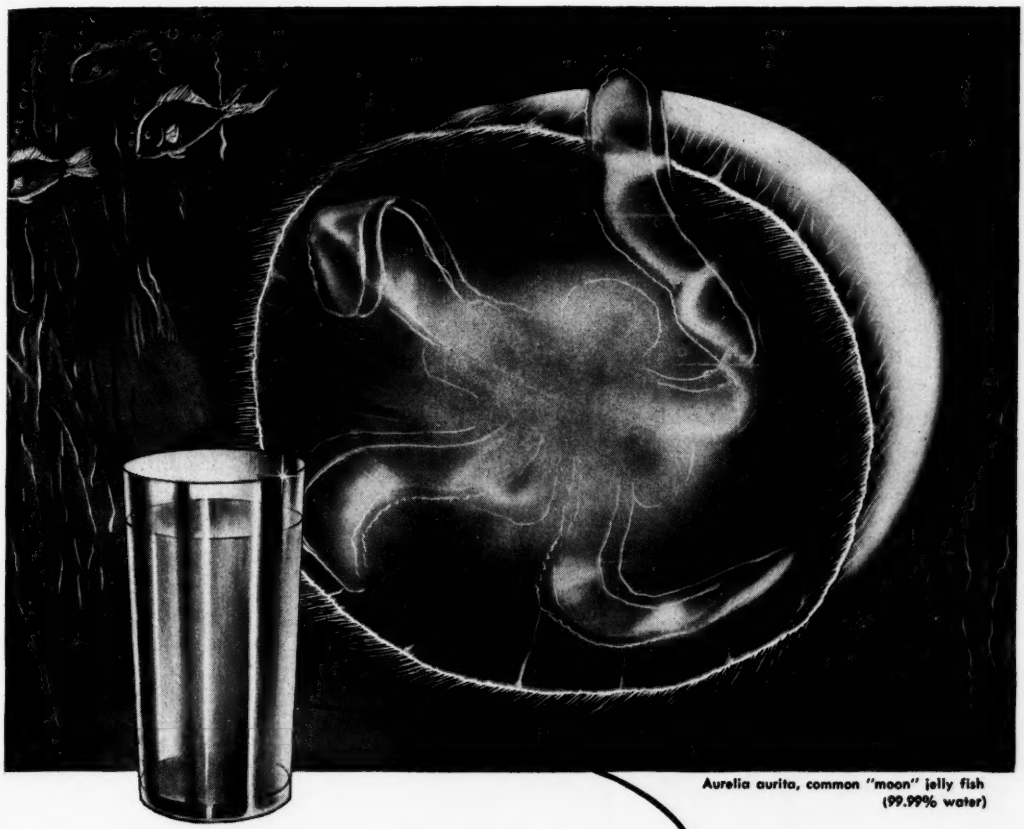
There was extensive discussion of the matter and Dr. Farrell climaxed it by stating that the Society has officially spoken in the matter and therefore every Fellow should cooperate, or if dissatisfied with the action should protest to the district society or the House of Delegates requesting that the action be rescinded, held in abeyance or otherwise considered. He expressed the opinion that every district should be notified of the action taken and should be requested to abide by the action of the House.

After further discussion the motion was made that a letter be sent by the Secretary of the Society to every Fellow, and in addition a letter to the Secretary of each district society to be read at it regular meeting, reviewing the action taken by the Society regarding insurance fees and stipulating that this was an official action of the Society which requires the response and cooperation of every Fellow until such time as the action may be changed. The motion was seconded and adopted.

The meeting adjourned at 10:45 p.m.

Respectfully submitted,

MORGAN CUTTS, M.D., *Secretary*



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BOOK REVIEWS

A MANUAL OF PHARMACOLOGY AND ITS APPLICATION TO THERAPEUTICS AND TOXICOLOGY, By Torald Sollmann, M.D. Phil.: W. B. Saunders Company. 7th ed., 1948, $11.50

This revised edition of Sollmann's book has some outstanding characteristics which make it an advance in pharmacological text books. The subject matter is presented in a manner which integrates the material discussed with its clinical applications. This characteristic is emphasized if the treatment of subject material in the new edition is compared with an older edition.

The present volume very adequately covers advances in such fields as the antibiotic agents, the antihistaminics, and the nitrogen mustards. The treatment of the older drugs is characterized by the emphasis on well established recent facts and the elimination of unnecessary speculation.

The bibliography is quite complete and the new arrangement of two columns to a page makes for easier reading.

W. J. H. FISCHER, JR., M.D.

DISEASES OF THE CHEST, Emphasizing X-ray Diagnosis, By ELI H. RUBIN, M.D. W. B. Saunders Co., Phil., 1947. $14.50

The author has set himself a rather ambitious program and in so far as is possible I believe he achieves this goal. However, it must truthfully be said that the author rides off in all directions at once. He tries to be all things to all people, and because of this the book can be criticized justly.

First of all, for a trained Radiologist the X-ray discussion is too superficial and too sketchy. For the non-trained clinician, even if he is a chest specialist, the X-ray discussion is again, to my mind, inadequate.

With justice it must be said that the X-ray discussion ties in very well with the clinical data for those men who have had training in X-ray. Personally, I found the discussion of Tuberculosis possibly the best part of the whole book. Here, and throughout, the illustrations are excellent.

The author's arrangement of this vast subject is the best possible. From a Radiologist's viewpoint the chapters on pre-operative and post-operative care again seem comprehensive but sketchy.

In summary, it must again be said that criticism is directed to the objective of the book, which is too ambitious, rather than to the method of dealing with the subject. Had the author decided to write a book on Diseases of the Chest from a clinician's point of view, tying in, throughout, X-ray, physiology, and surgery as necessary, the book might even be better than it is. I found it very profitable reading, as I am sure others will.

EUGENE A. FIELD, M.D.

GENERAL ENDOCRINOLOGY, By C. DONNELL TURNER, PH.D.
W. B. Saunders Co., Phil., 1948. $6.75

This is a very readable and up-to-date textbook of Endocrinology. It is written from the point of view of general biology rather than medicine. It presents the subject in a broad way, as an experimental science. While a large part of the material is mammalian, the lower vertebrates and the invertebrates, especially the insects, are adequately treated. Plant hormones are included in the general discussion. The introductory chapter includes a summary of the history of endocrinology and is followed by a chapter on the biology of secretion which treats of chemical coordinators in the organism generally and serves as a background for the specialized chapters that follow. The illustrations are well chosen and excellent. There is an adequate bibliography at the end of each chapter in which preference is given to monographs and recent reviews. While it is designed primarily for students in a university course, the book is heartily recommended for the general reader.

J. WALTER WILSON
Brown University

SYMPOSIA ON NUTRITION OF THE ROBERT GOULD RESEARCH FOUNDATION, Vol. I, Nutritional Anemia, Edited by Arthur Lejwa, The Robert Gould Research Foundation, Inc., Cincinnati, Ohio, October 16, 1947.

This volume comprises a series of eleven papers prepared by oustanding hematologists for a recent symposium. The papers bear principally upon those aspects of anemic diseases which are influenced by nutritional factors such as folic acid, iron,

copper, the vitamin B complex and vitamin C. The papers herein presented will have their chief value as sources of reference (they have rather extensive bibliographies) and for those whose primary interest is hematology or nutrition.

IRVING A. BECK, M.D.

***ADVANCES IN INTERNAL MEDICINE,* Vol. II. Edited by William Dock, M.D. and I. Snapper, M.D. New York: *Interscience Publishers, 1947.* $9.50**

The aim of this series to brief the internist and others on outstanding recent advances in internal medicine and related fields is well met. A wide range of subjects is presented.

In the field of the cardiovascular system the section on "Circulatory Failure Studied by Means of Venous Catheterization" and the "Discussion of Angiocardiography and Angiography" are particularly important, especially for those who have not had an opportunity to work directly in these fields.

The section on "Surgical Treatment for Hypertension" points out the outstanding problems in this field. The tendency to increasingly extensive sympathetic denervation is noted. The discussion of the use of penicillin in bacterial endocarditis and in other infections has as its only failure the almost unavoidable one of not being able to present material in a fast moving field which is not somewhat outdated when it is published. The section on the anemias contains a good consideration of what has been recently one of the most interesting developments, namely, the role of Folic Acid. The indexing is detailed and entirely satisfactory.

W. J. H. FISHER, JR., M.D.

A-B-C'S OF SULFONAMIDE AND ANTIBIOTIC THERAPY, by Perrin H. Long, M.D., F.R.C.P., W. B. Saunders Company, Philadelphia and London, 1948.

This is a concise summary of our present day knowledge of sulfondamides and antibiotics. It apparently is designed primarily for the busy practitioner so there are no lists of references and the information is set forth explicitly and unequivocally. The very arbitrariness of this presentation leaves the author open to criticism that he has not included certain divergences in current opinion. However, when devising a book for actual use by individuals possessing no special training in the changing field of infectious disease therapy it is perhaps the wiser plan to have a certain arbitrariness of presentation. Advise as to therapy has been simplified by outlining standard dosage schedules which are applicable to a number of different infections. There is a brief outline of the clinical pharmacology of these medications. Under toxic mani-

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BOOK REVIEWS

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festations the author cites a warning which, unfortunately, has not received sufficient attention, namely, that the quickest and most consistent method of producing a generalized sensitivity is by the local treatment of open dermal lesions with topical preparations of penicillin or the sulfonamides.

Most of the common infectious diseases in which one or both of these forms of therapy may be applicable are listed in alphabetical order and the treatment of choice given. The author is forthright in indicating that in certain conditions in which these drugs are at present used rather widely, such as the common cold or influenza, their use is unnecessary, wasteful, and may lead to sensitization. A description of auxiliary therapy has been included for many of the diseases.

The conciseness, the explicitness, and the relatively small physical size of this volume make it available as a quick, practical reference without detailed reading, such as one might want on the practitioner's desk or in the interne's coat pocket.

IRVING A. BECK, M.D.

CORRELATIVE NEUROANATOMY By Joseph J. McDonald, M.S., M.Sc.D., M.D., Joseph G. Chusid, A.B., M.D., Jack Lange, M.S., M.D. Fourth Edition, Revised (60 Illustrations), *University Medical Publishers, PALO ALTO, CALIFORNIA*

This presentation is the fourth revision of this useful text which was first issued in 1938. Its usefulness is derived from its composite arrangement which is simple but more complete than many more noted textbooks; and its availability since it is within the price range of all students and practitioners. This has been made possible by outline form in lithoprint, reproduction of flat drawings, and loose-leaf type of binding.

The principles of neurodiagnosis are presented in correlation with anatomical divisions of the nervous system rather than with clinical entities as presented in earlier editions. The section on diseases of the central nervous system follows an eclectic arrangement, augumented by more detailed descriptions and a more complete list of syndromes. The bibliography is short but refers the reader to standard works of proven reliability. The illustrations, set opposite the related anatomical descriptions are one of its best features.

HANNIBAL HAMLIN, M.D.

PROVIDENCE MEDICAL ASSOCIATION

concluded from page 683

Dr. Wilson gave an excellent paper on beryllium poisoning. This substance is used in fluorescent lighting, electronics etc. The dust is inhaled and causes lung damage. The condition may be acute or may be chronic, also the symptoms may not become manifest for three years after exposure.

There are three different types according to x-ray findings.

1. Granular.
2. Granular-nodular.
3. Nodular with emphysema.

In the chronic form the granulomas are miliary and uniform in destruction. They do not calcify or cavitate and do not involve the pleura.

The severity of the symptoms vary according to the amount of exposure. There is substernal pain, dyspnea, cough, weight loss, and anorexia. Occasionally gastro-intestinal symptoms occur. Pathologically the lesions are found both in the alveoli and the supporting framework. The treatment is symptomatic and many cases progress to death.

Dr. Ham had one patient with this disease. He was extremely sick and upset mentally and it was difficult to distinguish the nervous reactions from the reactions to the disease. This patient ended with extreme cyanosis and clubbed fingers, with frequent exacerbations of the disease.

The meeting was adjourned at 11 p.m.

Attendance 65

Collation was served.

Respectfully submitted,

DANIEL V. TROPPOLI, M.D., *Secretary*

READY TO HELP CARDIAC CHILDREN

The Children's Heart Association of Rhode Island reminds the physicians of the State that it stands ready to help them in the care of those children with heart disease. The Association will arrange to set up programs of education, occupational therapy, and volunteer visiting in order to relieve to some extent the patient's burden of weeks in bed, as well as offer relief to the parents of the patient. The Association also conducts a camp program in the summer. To a limited extent the Association can arrange for supplementary financial assistance in some cases requiring convalescent hospital care.

HAROLD G. CALDER, M.D., *President*
Children's Heart Ass'n of R. I.